Social Anxiety Disorder  Caleb W. Lack, Ph.D.  University of Central Oklahoma	
Outline of Workshop  1. Overview of social anxiety disorder  2. Overview of SAD treatment  3. Treatment breakdowns and specifics	
Overview of SAD	

### **Operational Definition**

- A. Marked fear or anxiety about one or more social situations in which the person is exposed to possible scrutiny by others.
- B. The individual fears that he or she will act in a way, or show anxiety symptoms, that will be negatively evaluated
- C. The social situations consistently provoke fear or anxiety

# **Operational Definition**

- D. The social situations are avoided or endured with intense fear or anxiety
- E. The fear or anxiety is out of proportion to the actual danger posed by the social situation.
- F. The duration is at least 6 months.
- G. The fear, anxiety, and avoidance cause clinically significant distress or impairment in social, occupational, or other important areas of functioning

### **Operational Definition**

- H. The fear, anxiety, and avoidance are not due to the direct physiological effects of a substance or a GMC
- I. The fear, anxiety, and avoidance are not restricted to the symptoms of another mental disorder
- J. If a general medical condition is present, the fear, anxiety, or avoidance is clearly unrelated to it or is excessive.

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### **SAD Specifiers**

- Performance only: If the fear is restricted to speaking or performing in public
- Generalized: If the fear is of most social situations (and is not restricted to performance situations)
- Selective Mutism: Consistent failure to speak in specific social situations (in which there is an expectation for speaking, e.g., at school) despite speaking in other situations

#### **SAD Behavioral Definitions**

- Overall pattern of social anxiety or shyness that presents itself in most social situations
- Hypersensitivity to criticism or disapproval of others
- No close friends or confidents outside of firstdegree relatives
- Avoidance of situations that require a degree of interpersonal contact

#### **SAD Behavioral Definitions**

- Reluctant involvement in social situations out of fear of saying or doing something foolish or of becoming emotional in front of others
- Debilitating performance anxiety and/or avoidance of required social performance demands
- Increased physiological response in social situations

#### SAD Prevalence

- 7.1% for 12 months, 12.1% for lifetime in US
- Similar rates across Western countries, seen across all cultures in varying rates
- *Taijin kyofusho* in Eastern countries appears to be a culturally specific form of SAD

Stein & Stein (2008)

#### **SAD Onset**

- Early onset compared to many disorder, with rates of 6.8% in children
- 50% of adult cases report onset in childhood, over 80% reported starting by age 20
- Only half ever seek treatment, average time is after 15-20 years of diagnosable problems

Bogels et al. (2010); Stein & Stein (2008)

### **Gender Differences**

- Higher rates of females in both adult and adolescent samples
- However, men more likely to seek treatment
- Different common symptoms
  - Men eating in restaurants and writing in public
  - Women using public restrooms and speaking in public

Ranta et al. (2007); Weinstock (1999)

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### **SES & Cultural Differences**

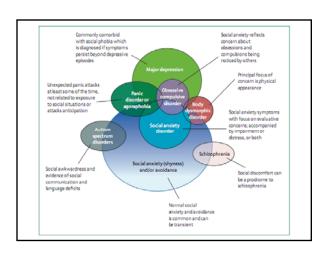
- More prevalent in low SES and less educated
- Fear of embarrassing self (Western) versus fear of offending others (Eastern)
- Native Americans at higher risk that whites or African-Americans, but this changes across ages

Lewis-Fernandez et al. (2009)

# Comorbidity

- Very high, over 80% in clinical settings
- Most common are depression, panic disorder, GAD, specific phobias, and alcohol use disorders
- SAD often develops prior to comorbid problems, but relationship with AUD is uncertain
- Avoidant PD may be an extreme variant of SAD

Morris et al. (2005); Stein & Stein (2008)



### Impact of SAD

- Common reason for school refusal in youth
- Only internalizing disorder highly associated with dropping out of school early
- Reduced workplace productivity, higher unemployment
- Reduced health-related QoL

Stein & Stein (2008)

### Impact of SAD

- High rates of being single or divorced
- Wide range of sexual dysfunctions
- Smaller social networks and less social support
- Greater risk for suicide than general population
- Lowered positive psychological experiences

Kashdan (2007)

### Etiology

- Behaviorally inhibited temperaments place individuals at high risk for SAD
- Modest heritability of SAD, likely due to BI or introversion, but could be shared environment
- Multiple gene variants and neurotransmitters seem to play a role (no one pathway)

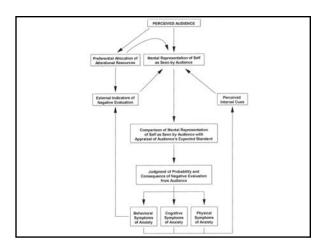
Morreale et al. (2010)

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# Etiology

- Family environment reported to be more overprotective, less affectionate
- Families also emphasize concern of other's opinions, lack of family sociability
- CBT model emphasizes role of negative aspects of self and situation

Morreale et al. (2010)



**Overview of SAD Treatment** 

### Treatment for Social Anxiety

- Large evidence base for pharmacology and psychotherapy, individually but not combined
- Effect sizes are roughly equal for SSRIs and CBT (1.5 vs 1.8)
- SSRIs work sooner, but CBT effects last longer

Stein & Stein (2008)

# Pharmacology for SAD

- SSRIs (but not Prozac) or SNRIs are first line choice
- D-cycloserine (glutaminergic agent) may be useful as an adjunct to exposure therapy
- MAOIs and benzodiazepines can be useful, but are more a) dangerous or b) addictive

Stein & Stein (2008)

	Dose (mg per day)	Number of patients	Response rate for drug	Response rate for placebo
Citalopram <sup>85</sup>	40	36	50%	8%
Scitalopram101,102	5-20	1028	54-71%	39-50%
luvoxamine103-105	50-300	422	43-48%	7-44%
luoxetine <sup>97,106</sup>	20-60	108	40-51%	30-32%
aroxetine*****	20-50	2188	55-72%	8-50%
Sertraline96.111-113	50-200	616	40-53%	9-29%
/enlafaxine108,114-116	75-225	1547	44-69%	30-36%

#### **CBT for SAD**

- Treatment for SAD is longer and involves more components than for specific phobias
  - Psychoeducation
  - Applied relaxation
  - Social skills training
  - Cognitive restructuring
  - Imaginal and in-vivo exposure

Rodebaugh et al. (2004)

# Psychoeducation

- Provides information about SAD, including
  - Symptoms
  - Etiology
  - Research on types of treatments
- Ends with an orientation to the CBT model of SAD and an introduction to treatment

# **Applied Relaxation**

- Train clients in progressive muscle relaxation (PMR)
- Instructed to practice using PMR during daily activities
- When the client is sufficiently skilled, practice while confronting feared situations

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### Social Skills Training

- Often used when a deficit in social interactions is blamed for anxiety
- Uses modeling, skill rehearsal, corrective feedback, and reinforcement to shape skills
- Equivocal findings on if those with SAD actually have skills deficits, though

### **Cognitive Restructuring**

- Based on that fact that it is a person's interpretation of a situation, not the situation itself, that causes the anxiety
- Focuses on identifying automatic negative thoughts that are causing distress, then learning to argue against those thoughts

### **Exposure with Response Prevention**

- Client is exposed to feared social situation, then prevented from engaging in escape or avoidance behaviors until non-anxious
- Usually work up a hierarchy from least to most feared situations


#### **CBT for SAD**

- EX/RP appears to be the most important ingredient among the components
  - CBT vs only exposure yield similar results
- Have to take care to catch and not allow subtle avoidance and focus on the situation itself
- Safety behaviors must also be curbed

Rodebaugh et al. (2004)

### **CBT for SAD**

- Applied relaxation trains clients in PMR, and then has them implement it *in vivo* 
  - PMR *alone* is not an effective treatment
- Similar to systematic desensitization, in which the likely active ingredient is EX/RP
- Likely the case for social skills training as well

Rodebaugh et al. (2004

#### **CBT for SAD**

- Cognitive restructuring is often used to help prepare for exposures
- Exposures are seen as the "test" of if automatic negative thoughts are correct
- But again, EX/RP may be the key task

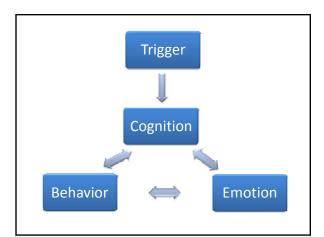
Rodebaugh et al. (2004)

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# EX/RP & Cog Restructuring

- Dichotomizing the two may be misleading
- Therapists may be mixing the two, rather than strictly using one or the other
- Behavior causes changes in thoughts, thoughts cause changes in behavior

Rodebaugh et al. (2004)



### **CBT for SAD**

- Gains or even improvements seen from 6-12 months post treatment
- Low drop-out rates (10-20%)
- Group and individual formats both show large improvement rates, but individual is higher

Rodebaugh et al. (2004); Stein & Stein (2008)

#### Access to CBT

- With limited access, self-guided/minimal contact therapies may be a useful alternative
- One study found bibliotherapy + 3 hours of non-therapy contact with therapist clinically improved 40% of clients
- May be good option for mild-moderate SAD

Abramowitz et al. (2009)

**Treatment Breakdown & Specifics** 

### Long-Term Goals for SAD

- Interact socially without undue fear or anxiety
- Participate in social performance requirements without undue fear or anxiety
- Develop the essential social skills that will enhance the quality of relationships
- Develop the ability to form relationships that will enhance recovery support system
- Reach a balance between solitary time and interpersonal interactions with others

# Short-Term Objectives

- 1. Describe history and nature of social fears and avoidance
- 2. Complete psychological tests designed to assess worry and anxiety symptoms

# Therapeutic Interventions

- Assess the frequency, intensity, and duration of panic symptoms, fear, and avoidance
- 2. Administer self-report measures to assess nature of phobia

### Short-Term Objectives

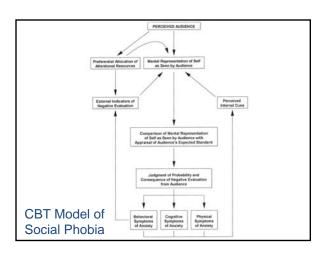
3. Verbalize an accurate understanding of the vicious cycle of social anxiety and avoidance

Verbalize an understanding of the rationale for treatment

# Therapeutic Interventions

3. Discuss CBT model of anxiety, focusing on both negative reinforcement of avoidance and cognitive biases responsible

Assign educational materials on anxiety for client to read



# Short-Term Objectives

4. Learn and implement calming and coping strategies to reduce overall physiological arousal and manage anxiety symptoms

# Therapeutic Interventions

4. Teach client relaxation skills such as PMR or DB, as well as attentional focusing skills to manage social anxiety symptoms

### Short-Term Objectives

5. Identify, challenge, and replace biased, fearful self-talk with reality-based, positive self-talk

# Therapeutic Interventions

5. Using cognitive restructuring to address both current and past anxiety-causing thoughts by challenging them and replacing them with more adaptive thoughts

# Short-Term Objectives

6. Undergo gradual repeated exposure to feared social situations, first in therapy and then in daily life

# Therapeutic Interventions

6. Construct fear hierarchy and perform exposures with response prevention to reduce learned avoidance responses to anxiety-provoking thoughts or situations

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# Short-Term Objectives

7. Learn and implement social skills to reduce anxiety and build confidence in social interactions

# Therapeutic Interventions

 Use instruction, modeling, and roleplaying to build and practice general or specific social skill deficits

Assign readings about communication or social skills

# Short-Term Objectives

8. Learn and implement relapse prevention strategies for future anxiety

# Therapeutic Interventions

 Discuss nature of anxiety, develop coping cards, use booster sessions as needed

### **Cognitively Focused Treatment**

- Based on knowledge that unwanted intrusive thoughts are normal
- It's not the intrusion that causes the anxiety and the compulsive behavior, but the appraisal of the intrusion
- Goal is to cognitively challenge appraisal and identify less threatening appraisals


### Subjective Interpretations

- Two broad types of thinking errors people make when confronted with a potentially stressful social situation:
- 1. Interpretation errors, where you misread the available information
- 2. Coping errors, where you misidentify things that protect you from a negative outcome

### Errors in Interpretation

- Catastrophizing
  - The worst possible outcomes are predicted or imagining that basic needs (safety, self-esteem, sustenance, etc.) are threatened
  - "Everyone will think I'm an idiot." or "I would die if happened."
- Faulty Estimates
  - An inaccurately high probability of danger is estimated.
  - "I will lose my job if I bring up a complaint to the boss."

### **Errors in Interpretation**

- Gross Generalizations
  - The danger perceived in one event is imagined to happen everywhere
  - You had someone ignore you in one situation, so you expect everyone will do the same
- Polarization
  - Aspects of danger associated with a person or situation are seen in absolute black-or-white terms.
  - Seeing things as either safe or dangerous, never inbetween

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### **Errors in Interpretation**

- Minimization of safety factors
  - Facts that indicate protection or safety are minimized or ignored.
  - Even though you've prepared for a presentation, knowing you are going to forget everything

# **Errors Related to Coping**

- Minimization of Coping Capability
  - Expression of a lack of control or helplessness are not in line with your capabilities
  - "I don't know what I would do if that happened"
- Unrealistic expectation for outcome
  - Expectation for outcome is expressed in terms of perfection, certainty, or control
  - "I can never make any mistakes"

### **Thinking Errors**

- Usually not necessary to have the client try and label what types of thinking errors they are making
- Therapist can judge the client's errors and just discuss those ones they are evidencing

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### **Challenging Thoughts**

- Can I say that this statement is 100% true, without any exceptions?
- What is the likelihood or probability of this happening?
  - Rate this twice, once emotionally and once objectively
- Does this statement fit with all the available evidence?

# **Challenging Thoughts**

- Am I ignoring any safety factors?
- Does this always apply? Are there conditions under which this might not apply?
- Is there a gray area to this statement (not just a black and white thing)?
- Is this based on fact or feeling? Have my feelings ever turned out to be wrong?

### **Challenging Thoughts**

- How much control do I actually have in this situation?
  - Am I taking responsibility for things over which I have no control?
  - Am I ignoring aspects of the situation that I can control?
- Is my expectation for this outcome realistic or even possible?

### The Thought Record

- This is a physical manifestation of the thought challenging process
- Often used early in therapy to help client generalize CR skills outside of therapy
- Should be customized for the age and/or developmental level of the client

	THOUGHT RECORD
ρ	Trigger:
reco	Cognitions (images, thoughts, assumptions, and/or beliefs):
ght	Strength of belief in cognitions (on a 1-7 scale):
hou	Challenges to cognitions:
an adult thought record	Types of thinking errors:
an ac	Alternative viewpoints:  • Worst outcome:
	Best outcome:
O O	Most realistic outcome:
ldπ	What effect does this thought have on the way I feel?
Example of	Rational responses:
ш	Even though I feel that is true,  (thoughts or assumptions)
	the reality is that
	(answers to challenges and alternative viewpoints)

# Using the Thought Record

- When teaching clients, it is important to make sure that they are recognizing thoughts and emotions accurately
- Practice in session with two-three records before clients do them on their own
- Review the records they did as homework the next week and make corrections as needed

### Modified Thought Challenging

- Many clients may find it inconvenient to complete a TR at certain times of the day
  - E.g., at work or school
- Mental completion is encouraged when one cannot do the written TR
- Many clients respond well to a "mini-TR"
  - Printed small so that it fits into a pocket and can be concealed but is easily available

#### MINI-THOUGHT RECORD

- 1. What happened that made anxiety pop up?
- 2. What anxiety told me or wanted me to ask?
- 3. How much do you believe anxiety?
- 4. How does this make me feel?
- 5. What did you tell anxiety to fight back?
- 6. What would be the.....
- Worst outcome? (if anxiety was right)
- Best outcome? (if anxiety was wrong)
- Most likely outcome?

### What are Exposures?

- Placing a client in an anxiety or fear inducing situation (exposure), and not allowing them to use avoidance or escape behaviors (response prevention)
- Client stays in the presence of the fear stimulus until it no longer causes anxiety or distress
  - This is called habituation, and breaks the negative reinforcement cycle of the escape behaviors

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#### **Groundwork for ERP**

- Conveying effectiveness and competence
  - Use past clinical examples as well as research data to show that the treatment works
- Forming an effective therapeutic alliance
  - Praising client for entering therapy
  - Including client-specific examples when during psychoeducation
  - Taking a strong, nonjudgmental stance
  - Collaborative efforts to design exposures

### **Groundwork for ERP**

- Selling the rationale
  - Describe therapy procedures clearly
  - Reassure client that it is okay to be afraid during the exposures, but that she will get better
  - Using analogies to increase understanding
  - Accept she may have tried something before, but emphasize the different nature of ERP
- Tailor treatment to the individual

### Creating a Fear Hierarchy

- Therapist must accurately assess the feared situations using self and other report, as well as behavioral observations
- A dynamic process that continues throughout therapy
- Generate and then sort the specific situations that cause anxiety, including how often they are avoided

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ACTIVITY	FEAR	AVOIDANCE
Job Interview	10	0
Applying for Jobs	9	9
Going to a party	8	7
Dinner party w/friends	6	3
Calling someone for the first time	6	4
Returning a call	3	4
Asking a question of a stranger	2	4

# **Assessing SUDs**

- After generating the anxious situations, they are then rated using Subjective Units of Distress
- SUDs can be adjusted to the developmental level of the client: 0-5, 0-8, 0-10, 0-100
- Used to both order the hierarchy and assess distress during exposures

# **Types of Exposures**

- Imaginal exposure tasks
  - Often used in the beginning, or when the client has abstract worries / fears
  - Allows for practicing coping skills before confronting the real situation
- In vivo exposure tasks
  - Often follow imaginal exposures, use a "live and in person" version of the feared situation


### **Basics of Exposure**

- Exposure occur both in and out of session
- Often requires cooperation of parents/significant others to facilitate successful homework exposures
- Should be similar to what is being done in session, using a hierarchy and SUDs ratings
- Internal and external rewards for successful exposure completion should be discussed beforehand

# **Basics of Exposure**

- Ideal exposures are prolonged, repeated, and prevent the use of distraction behaviors
- SUDs decrease of at least 50%, with more being better
- May require shaping up to the more difficult situations, in terms of both time and use of distractors

### **Therapist Tasks**

- Realize long-term benefits outweigh shortterm distress, and communicate this effective to the family
- Work collaboratively with the client and family to plan and execute the exposures
- Maintain rapport during exposures by building upon pre-established rapport

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### **Therapist Tasks**

- Do not allow avoidance or distracter behaviors during the exposure
- Modeling how to conduct appropriate exposures for significant others, so that they can perform them outside session
- Be flexible and creative when dealing with less than optimal exposures and resistance

# Obstacles for the Therapist

- I'm making my client more upset / anxious
- It's difficult to see people in distress
- Hearing the accounts of trauma can be emotionally draining for some people
- May have to do exposures that *you* are not comfortable with

Questions? Discussion?
